WHITE HOUSE CONFERENCE ON AGING
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Policy Recommendation

Medicare should provide reimbursement for technologies that can proactively reduce cost, increase alternatives to acute and long term care, and enhance care outcome for the Medicare recipient

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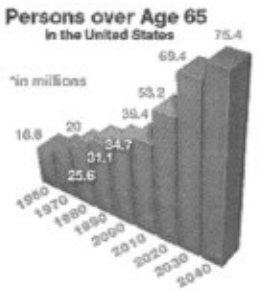
Policy Recommendation Statement

Thirteen percent of the population or 33 million Americans are over 65 years of age. Their ranks will more than double by the year 2030. The number of seniors with disabilities and reduced capacity to cope with activities of daily living will increase proportionately with the "age wave". Many will need in-home, acute and long term care services that will be paid for by Medicare. Medicare should provide reimbursement for technologies that can proactively reduce cost, increase alternatives to acute and long term care, and enhance care outcome for the Medicare recipient.

Overview



The aging of America will affect us as unlike no other issue. While Americans are faced with many factors (economic, political, and technological) that may have impact on lifestyle, employment, and so forth, demographically speaking, we know a lot about what the future holds for seniors. Undoubtedly the boomer generation is going to live longer and be healthier than any previous generation. Each succeeding American generation has. Combine longevity with the fact that the "boomers" neglected to produce enough children over the years to support their old age and the result will be, in a short time, only 1.5 workers for every retiree/dependent in America. This combination of a very large mature population and a very low supporting population will create a real life "worst case" scenario.

The future is now. One of the key issues for "Baby Boomers" will be the need for care alternatives to deal with the various conditions that come with aging that make daily activities difficult. In fact, by the age of 65, nearly 17% of Americans need some support with the every day activities of living. By age 85, nearly half need this help. The type of care needed by most seniors is not medical care, but supportive care. They don't need, or want, a nursing home (indeed, only 5% are in nursing homes), but they do need caregiver support and in home services to remain independent in their own home. The number of family caregivers is declining in America and the increase demand for elder care is inevitable:

- A quarter of U.S. households are now involved in caring for an elderly family member or relative, spending an average of 20 hours a week in care giving. Eighty percent of caregivers provide unpaid assistance seven days a week.
- Lost productivity, absenteeism, interruptions and replacing employees due to elder care, costs American business in excess of $11.4 billion annually. (Source: National Alliance for Caregiving/Glaxo Welcome Report, 1997)
- More than 60% of all family caregivers say they have suffered from depression. (Source: National Family Caregivers Association/Fortis Long Term Care, 1998)

The Issue

There are current technologies that are available that can reduce the cost of care and caregiver stress. While Medicare reimburses providers for many in-home services, there are technologies that are not being reimbursed that can reduce costs, improve care giving capabilities, and may enhance care outcomes, while retaining the independence of seniors. The lack of payment is a barrier to the provider's ability to offer cost-saving alternatives to the institutionalization of seniors.

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Medicare should provide reimbursement for technologies that can proactively reduce cost, increase alternatives to acute and long term care, and enhance care outcome for the Medicare recipient. The Medicare Program needs to implement the following:

1. Increase the use of in-home technologies to reduce unnecessary admissions to acute and long term care facilities – See Quiet Care Cost Comparison;
2. Use Medicare reimbursement to encourage the application of in-home technologies that reduce the need for institutionalization of seniors – See Quiet Care Cost Comparison;

COST COMPARISON

QuietCare℠	Home Health Aide	Adult Day Care	Assisted Living	Hospitalization	Nursing Home Semi-Private
$2.99/day	$18.12/hour[1] 29hours/week[2]	$50/day[3] $250/week		$1,300/day[5] 6.1 days[6] $7,900/stay	$181.24/day[7] $1,268/week
$79.95/month	$2,100/month	$1,000	$2,524[4]		$5,074
$959.40/year	$25,000/year	$12,000	$30,288		

[1]Source: National Average The MedLife Market Survey of Nursing Home and Home Care Costs, August 2003
[2]Source: National Clearinghouse on the Direct Care Workforce, September 2004 Fact Sheet. Paraprofessional Healthcare Institute September 2004
[3]Source: NCOA/NADSA Survey
Health, U.S. U.S. Dept. of Health and Human Services
[4]Source: National Average The MedLife Market Survey of Assisted Living Costs, October 2004
[5]Source: Health, U.S. U.S. Dept. of Health and Human Services
[6]Source: U.S. Centers for Medicare and Medicaid Services, based on data reported by the American Hospital Association.
[7]Source: Health, U.S. U.S. Dept. of Health and Human Services

3. Encourage acute and long term care facilities to compete on the basis of providing in-home technologies that are cost reducing, rather than cost-enhancing;
4. Stimulate research and development of cost-reducing technology and service innovations that can reduce dependence on the traditional acute and long term care model for meeting current and future healthcare needs.
5. Facilitate review of patient care outcomes given alternative settings[8,9,10]

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[8]Source: Institute of Medicine, Committee on Quality of Health Care in America. To Err Is Human: Building A Safer Health System. Kohn LT, Corrigan JM, Donaldson MS (Eds.). Washington, DC: National Academy Press; 1999. An estimated 44,000 to 98,000 Americans die each year as a result of medical errors, making it the eighth leading cause of death. Costs attributable to medical errors are estimated at $17 billion to $29 billion annually
[9]Scource: Bates DW, Cullen DJ, Laird N, Petersen LA, Small SD, Servi D, Laffel G, Sweitzer BJ, Shea BF, Hallisey R, et al. Incidence of adverse drug events and potential adverse drug events. Implications for prevention. ADE Prevention Study Group. JAMA. 1995 Jul 5;274(1):29-34.
[10]Source: Gurwitz JH, Field TS, Harrold LR, Rothschild J, Debellis K, Seger AC, Cadoret C, Fish LS, Garber L, Kelleher M, Bates DW. Incidence and preventability of adverse drug events among older persons in the ambulatory setting. JAMA. 2003 Mar 5;289(9):1107-16.

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